Preferred Provider Network (PPN) Survey

PPNs are required to file all information in this survey with the Insurance Department prior to the start of enrollment and annually update thereafter on or before July 1st. Each managed care organization that fails to file the annual data requested in this letter shall pay a late fee of one hundred dollars per day for each day from the July 1 due date.

Name of PPN:_____

Name of PPN Parent Company:_____

PPN Address:_____
_____

Contact Information:

Name:_____ **Title:**_____

Mailing Address:_____
_____
_____

Phone number:_____ **FAX number:** _____
E-mail address:_____

Does your PPN provide services only for workers' compensation or self-insured arrangements?

[ ] **NO**

[ ] **YES** (Indicate type(s) of arrangements below)

[ ] Workers compensation

[ ] Self-insured arrangements

If YES, you are *not required* to complete the remainder of this survey. Please return this page and the signed certification to the Insurance Department, Life and Health Division at the address below**.**

If NO, you are required to complete the entire survey and return to the Insurance Department, Life and Health Division at the address below.

Mailing Address: P.O. Box 816
Hartford, CT 06142-0816

Office Address: 153 Market Street, 7th Floor
Hartford, CT 06103

The office address must be used for all express or special delivery mail or for hand delivery of any documents.

CERTIFICATION OF ACCURACY

I, _____, _____of
(Printed Name) (Title)

_____, hereby certify that
(Company or Organization)

I have reviewed the information submitted in accordance with Public Act 01-04 of the June 2001 Special Session, and that the information is true and accurate.

_____
(Signature)

_____
(Date)

-

Type of PPN: **[ ] Independent provider sponsored PPN**
[ ] Independent practice association
[ ] PPN established by health care center
[ ] PPN established by indemnity insurance carrier
[ ] Other (please explain e.g. Dental, Vision etc.)
_____

Name of Controlling company or organization: _____
Address: _____
_____
_____

Name of Related or predecessor company or organization: _____
Address: _____
_____
_____

Explain current relationship with related or predecessor company:

_____
_____
_____

[ ] Attached is a Certificate from the Secretary of State regarding the company's or organization's good standing to do business in the state. For out of state companies or organizations, a certificate that such company or organization is in good standing in its state of organization. [Only required if the PPN has not submitted a Certificate in 2002 (or later) survey]

[ ] Attach a copy of company's or organization's balance sheet as of the end of the most recently completed fiscal year.

- **Name the public accounting firm or internal accountant if one was used to prepare or assist in the preparing the balance sheet:**
  _____

[ ] Attach a list of the names, official positions and occupations of board of directors or other policy-making body and of those executive officers who are responsible for the company's or organization's activities with respect to the medical care network.

[ ] Attach a list of the principal owners.

Has any suspension, sanction or disciplinary action been taken against this PPN organization in Connecticut or any other state?

[ ] **No**
[ ] **Yes** **If yes, explain**:_____
_____
_____
_____
_____
_____
_____
_____

Describe the PPN's service area: _____
_____
_____

Number of participating hospitals: _____

List participating hospitals:
_____
_____
_____
_____
_____
_____
_____
_____
_____

[ ] **Attach a list of participating primary care and specialty physicians and other providers, including the number and percentage of the capacity of each to accept new patients**.

Name and address of the person to whom applications may be made for participation:
_____
_____
_____
_____
_____

[ ] **Attach the general criteria for selection and/or termination of providers**.

[ ] Indicate the type(s) of reimbursement arrangements that the PPN enters into <u>with Managed Care Organizations:</u>

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain:_____
_____
_____
_____
_____

[ ] Indicate types of services that the PPN provides for Managed Care Organizations.

[ ] Medical services
[ ] Utilization Review
[ ] Claims administration
[ ] Dental Services
[ ] Other – List types of services_____
_____
_____
_____
_____
_____

[ ] Indicate type(s) of reimbursement arrangements that the PPN enters into <u>with participating providers:</u>

[ ] Capitation
[ ] Fee for Service
[ ] Other -- Please explain:_____
_____
_____
_____
_____

[ ] List all Managed Care Organizations with whom PPN has entered contracts:

_____
_____
_____
_____
_____
_____